

## CERTIFICATE OF DEATH

12445

12454

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grantsville Rural</b> c. LENGTH OF STAY IN 1b <b>2 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Goodwill Mennonite Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1111 Woodington Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>F.</b> Last <b>Brand</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 30, 1897</b> 9. AGE (In years last birthday) <b>69 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Md.</b>
13. FATHER'S NAME <b>Robert Sipple</b>		14. MOTHER'S MAIDEN NAME <b>Martha Akehurst</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. V. T. ROSS</b>		124 Address <b>Ben Lomond St Uniontown Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> DUE TO (b) <b>Arteriosclerosis &amp; Hypertension</b> DUE TO (c) <b>Sev. years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>Sev. years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-24</b> , 19 <b>65</b> , to <b>9-7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-7</b> , 19 <b>67</b> , and that death occurred at <b>9:45 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Paul E. Berkebile</b>		22b. DATE SIGNED <b>9-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul E. Berkebile M.D.</b>		22d. ADDRESS <b>Meyersdale, Pa.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Sept. 9, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Pittsburgh Allegheny, Pa.</b>
24. FUNERAL DIRECTOR <b>Ruth Newman</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>16 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry Wilbert Canan</b>		4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1909</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>William, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Canan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Knotts</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-01-3195</b>	
17. INFORMANT <b>Mrs. Bessie Canan</b>		Address <b>see #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Compressed chest</b> DUE TO (c) <b>Truck bed fell on chest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>chest</b> <b>Working on truck bed which fell and compressed</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:50 p.m. 9-4 1967</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>(Rural) Oakland Garr. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		22. DATE SIGNED <b>67</b> Address (Street, city, town, or county) <b>Oakland, Md. 9-4</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/7/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>St. George W. Va.</b>	
24. FUNERAL DIRECTOR <b>Gerald N. Minnich</b>		25a. REC'D BY REGISTRAR <b>SEP 8 1967</b>	
ADDRESS <b>Oakland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

12446

12455



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon Pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12447 CERTIFICATE OF DEATH 12456

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crellin</b>		c. LENGTH OF STAY IN 1b <b>22 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crellin</b>		d. STREET ADDRESS <b>11-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George Marcellus Friend</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>25,</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Feb. 28, 1900</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Sines, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Friend</b>				14. MOTHER'S MAIDEN NAME <b>Mary Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-10-3712-A</b>		17. INFORMANT Address <b>Mr. Otis Friend Crellin, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of sigmoid Colon</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Carcinomatous metastatic</b> DUE TO (c) <b>from #1 above</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs. 4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>9:45</b>			
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Crellin</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 25, 1967</b> to <b>Sept 25, 1967</b> that (I) (we) last saw the deceased alive on <b>Sept 25, 1967</b> and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A.E. Mance</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>26 Sept 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.E. MANCE, M.D.</b>				22d. ADDRESS <b>3 SOUTH THIRD ST OAKLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ashby Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Crellin, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald D. Minnich</b>				ADDRESS <b>Oakland, Maryland</b>		25e. REC'D BY REGISTRAR <b>OCT 4 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

CERTIFICATE OF DEATH

1901

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12448

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12457

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Barbour</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>Minutes</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Philippi</b>		d. STREET ADDRESS <b>Route #2,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA - Garrett Co., Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard Dale Golden</b>		4. DATE OF DEATH <b>Sept. 25th. 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1945</b>
9. AGE (In years last birthday) <b>22</b> yrs.		10. IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mine</b>		12. INDUSTRY <b>Soft Coal</b>	
13. BIRTHPLACE (State or foreign country) <b>Barbour Co., W.Va.</b>		14. CITIZEN OF WHAT COUNTRY <b>USA</b>	
15. FATHER'S NAME <b>Lewie H. Golden</b>		16. MOTHER'S MAIDEN NAME <b>Luvada Foster</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>8254</b>	
19. INFORMANT <b>Proudfoot Funeral Home, Philippi, W.Va.</b>		Address	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIAATION</b> DUE TO <b>8254</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY HEMORRHAGE</b> DUE TO (c) <b>COMPRESSION OF CHEST</b>		INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>MINUTES</b> <b>MINUTES</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ASPIRATION OF STOMACH CONTENTS, TERMINAL</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto Accident Md. Rt. 219 Near Oakland, Md.</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:30 PM 9 25 1967</b>		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Preston, W.Va.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.		22. DATE SIGNED <b>9-25-67</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Oakland Garr., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Liberty</b>	23d. LOCATION (City or Town) (County) (State) <b>Barbour, W.Va.</b>
24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home, Oakland, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 27 1967</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



4408

NO. 107-2960 - 100

12458

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland, Md.</b>		c. LENGTH OF STAY IN lb <b>4 Days 8 Hrs:</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park, Md.</b>		11-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Garrett Co. Memorial Hospital</b>		d. STREET ADDRESS <b>122 East Second Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Archie</b> Last <b>Holland</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-7-95</b>
9. AGE (In years last birthday) yrs. <b>72</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Woodsmen</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Mt. Lake Park, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Holland, Kayle</b>		14. MOTHER'S MAIDEN NAME <b>Moon, Mary Elvina</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>212-12-8165</b>	
17. INFORMANT <b>(Wife)</b>		Address <b>Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO Arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>Arteriosclerotic cardio-vascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus. Old Cerebral vascular accident, left</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 <b>Sept 3</b> , 19 <b>67</b> that (I) <del>(we)</del> last saw the deceased alive on <b>Sept. 3</b> , 19 <b>67</b> , and that death occurred at <b>6:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. James H. Feaster, Jr.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>9-3-67</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. James H. Feaster, Jr.</b>		22d. ADDRESS <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/6/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garrett Co. Memorial Gar.</b>	23d. LOCATION (City or Town) (County) (State) <b>Oakland, Garrett, Md.</b>
24. FUNERAL DIRECTOR <b>John O. Durst</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1967</b>	
Leighton-Durst Funeral Home, Oakland, Md.		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

12450

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12459

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville</b>		c. LENGTH OF STAY IN lb <b>17 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Friendsville</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Lona Humberson</b>		4. DATE OF DEATH <b>Sept. 10, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21, 1897</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Friendsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Cornelius W. Friend</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Friend</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>- - - -</b>	
17. INFORMANT <b>David Humberson</b>		Address <b>Friendsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of stomach</b> DUE TO (c) <b>151X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		22. DATE SIGNED <b>9-11-67</b> Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/13/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Blooming Rose Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Friendsville, Md.</b>	
24. FUNERAL DIRECTOR <i>Sheldon N. Shinnick</i> ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

Garrett

17 yrs.

18 months

18 months

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18 months

18 months

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18 months

18 months

18 months

18 months

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12451

12460

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WVa</b> b. COUNTY <b>Mineral</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>35 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elk Garden</b> <b>85.3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Marshall Guy Johnson</b>			4. DATE OF DEATH Month <b>September</b> Day <b>29th</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-30-24</b>		9. AGE (In years last birthday) <b>43</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL</b>		11. BIRTHPLACE (State or foreign country) <b>WVa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Otis Marshall Johnson</b>		
14. MOTHER'S MAIDEN NAME <b>Edith Shillingburg</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW2</b>		
16. SOCIAL SECURITY NO. <b>234-32-7982</b>			17. INFORMANT <b>Mrs Kathleen J Johnson Elk Garden, WVa</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO (b) <b>CORONARY THROMBOSIS, LEFT</b> DUE TO (c) <b>CORONARY SCLEROSIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>9-29-67</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		Address (Street, city, town, or county) <b>Oakland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Metuchen Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Elk Garden Mineral WVa</b>		
24. FUNERAL DIRECTOR <b>Robert Kyle Prutts Sr. Hitzmiller, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



10-24  
10-24

10-24

10-24

## CERTIFICATE OF DEATH

12461

12452

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>13 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>20 S. 8th Street,</b>				d. STREET ADDRESS <b>20 S. 8th. Street,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR FORD JONES</b>				4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1903</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Medical Practitioner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Alleg. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dr. Emmett Lee Jones</b>				14. MOTHER'S MAIDEN NAME <b>Annie Ford</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>215-36-8813</b>		17. INFORMANT Address (Widow) <b>Mrs. A. F. Jones, Oakland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1621</b> IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Brucellosis</b> DUE TO (c) <b>Co. of lung 1 yr</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>24 Aug 1967</b> to <b>23 Sept 1967</b> , that (I) (we) last saw the deceased alive on <b>24 Aug 1967</b> , and that death occurred at <b>5:30 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Andrew E. Mance</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>25 Sept 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M.D.</b>				22d. ADDRESS <b>Oakland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/25/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Alleg., Md.</b>	
24. FUNERAL DIRECTOR <b>O. Durst</b>				25a. REC'D BY REGISTRAR <b>SEP 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

# STATE OF TEXAS

1891

County of \_\_\_\_\_ State of Texas

Know all men by these presents, that \_\_\_\_\_ of the County of \_\_\_\_\_ State of Texas

do hereby certify that \_\_\_\_\_ of the County of \_\_\_\_\_ State of Texas

is the owner of the following described land to-wit:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

# FOR-STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12453

12462

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>West Virginia</b> b. COUNTY <b>Grant</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>Minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(DOA) Garrett Co. Mem. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Harold Knotts</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>16th</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-7-07</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sanford Knotts</b>		14. MOTHER'S MAIDEN NAME <b>Emma Rinker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Margaret Wilson Knotts Gorman, W.V.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Coronary arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Prior heart attack 11 years ago</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.		22. DATE SIGNED <b>9-17-67</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-20-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Garrett County Mem. Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Oakland Garrett Md.</b>	
24. FUNERAL DIRECTOR <i>Wm. R. Whitehair</i>		25a. REC'D BY REGISTRAR <b>Terra Alta, W.Va.</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>SEP 22 1967</b>	

West Virginia State

Barrett

Donnell

Winters

Oakland

Local Service Co. and Hospital

Barrett

Donnell

Winters

John

50

10-7-71

John

John

West Virginia

Communication

Barrett

John

Barrett

50

John

Communication

John

Communication

Prior name: John H. Barrett

John

50

9-11-61

John

John H. Barrett, Jr., M.D.

Barrett

Barrett County, Md.

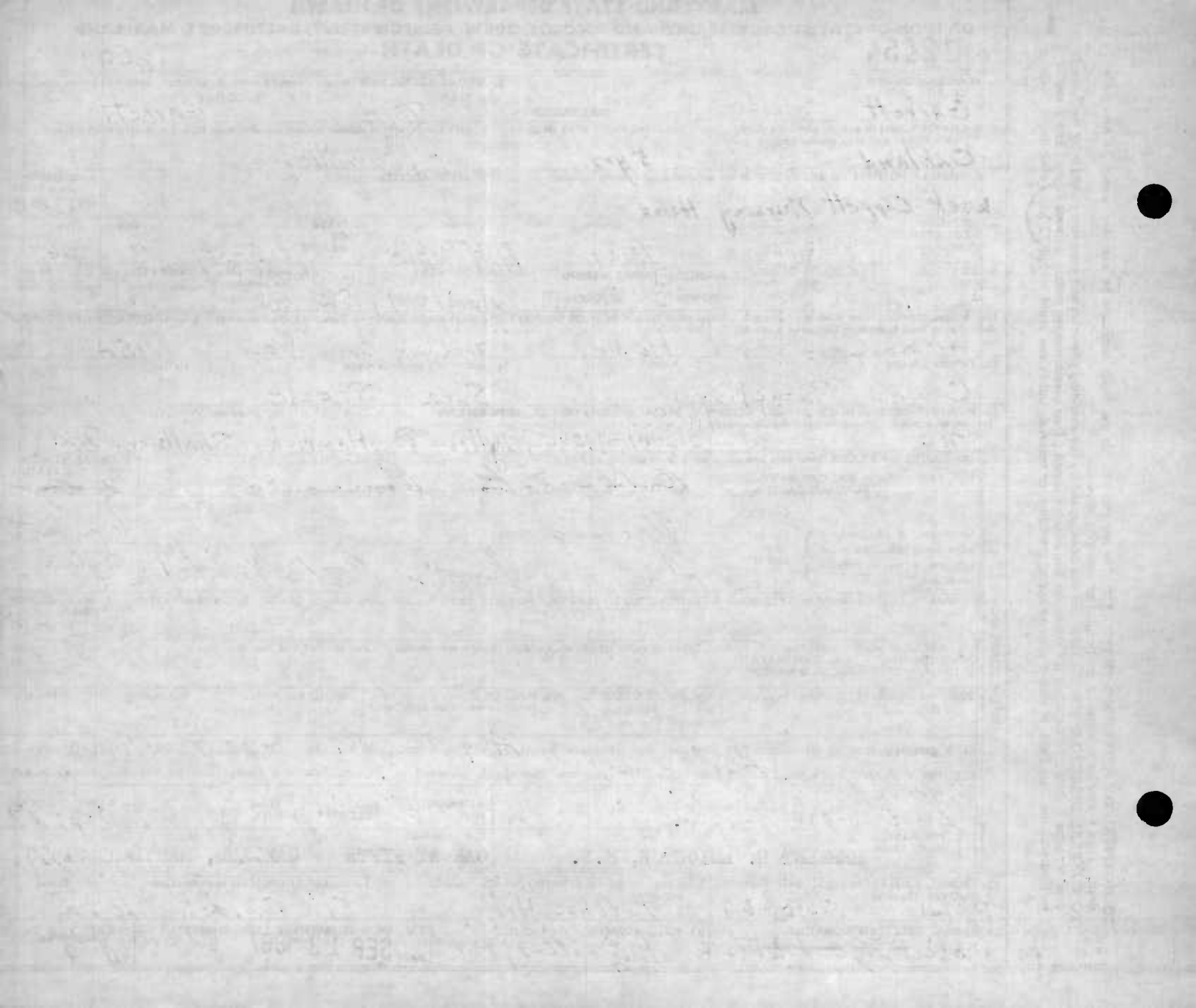
Barrett

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>Garrett</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kitzmillen</u>				d. STREET ADDRESS <u>11.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Week-Cuppert Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>BERTHA</u> First <u>THAY</u> Middle <u>McRobie</u> Last						4. DATE OF DEATH <u>Sept 7 1967</u> Month <u>Sept</u> Day <u>7</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11, 1885</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Fredrick Co. Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Owen Derflinger</u>						14. MOTHER'S MAIDEN NAME <u>Sara Steele</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>212-14-7728</u>		17. INFORMANT <u>Phyllis P. Hamrick Shallman, MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Orthostatic Pneumonia</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Uremia</u> (c) <u>Arteriosclerotic Cardio Vascular Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 months</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 12, 1967</u> to <u>Sept 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 26, 1967</u> , and that death occurred at <u>11.1</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Herbert H. Leighton</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7 Sept 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>HERBERT H. LEIGHTON, M.D.</u>						22d. ADDRESS <u>OAK AT FIFTH OAKLAND, MARYLAND 21550</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Hill</u>		23d. LOCATION (City, town or county) (State) <u>S.K. Garden W Va</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Kyle Pitts Jr.</u> ADDRESS <u>Kitzmillen, Md.</u>						25a. REC'D BY REGISTRAR <u>SEP 13 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			



CERTIFICATE OF DEATH

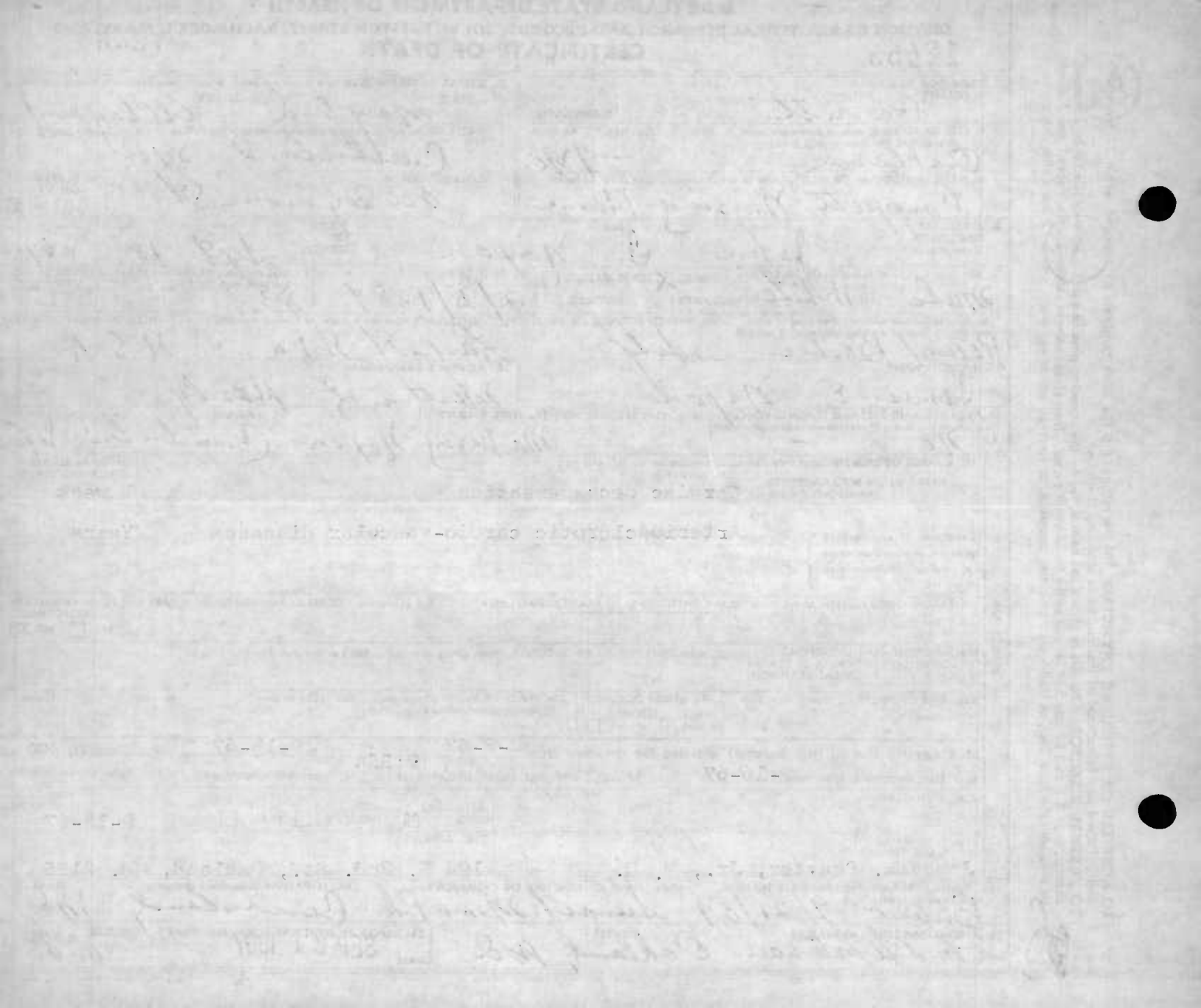
12455

12464

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN b. <u>-7 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cuppert Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u> d. STREET ADDRESS <u>200 Seymour St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>S.</u> Last <u>Nixon</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/1884</u>
9. AGE (in years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Largent N. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James E. Nixon</u>		14. MOTHER'S MAIDEN NAME <u>Martha L. Hardy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. Harry Nixon</u>		Address <u>Cumberland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardio-vascular disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-2-67</u> to <u>9-18-67</u> , 19....., that (I) <del>(XX)</del> last saw the deceased alive on <u>9-16-67</u> , 19....., and that death occurred at <u>9:35A</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>James H. Feaster, Jr.</u>		22b. DATE SIGNED <u>9-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. Feaster, Jr., M.D.</u>		22d. ADDRESS <u>104 S. 2nd. St., Oakland, Md. 21550</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Manor Ph. Cumberland Md.</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. H. Whitehair</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1967</u>	
ADDRESS <u>Oakland, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66



2  
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
12456					CERTIFICATE OF DEATH					12465				
1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Belleville</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Grantsville</b>			c. LENGTH OF STAY IN lb <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Belleville</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Goodwill Mennonite Nursing Home</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>E. Peachey</b> Last					4. DATE OF DEATH <b>Sept 2, 1967</b>		Month <b>Sept</b> Day <b>2</b> Year <b>19</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 17, 1885</b>		9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b> Hours <b>19</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Somerset Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>Enock Bender</b>					14. MOTHER'S MAIDEN NAME <b>Mary Yoder</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Nursing Home Records, Grantsville, Md.</b>			Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asotemia</b> DUE TO (b) <b>Nephrosclerosis</b> DUE TO (c) <b>Diabetic mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>3 wks</b> <b>2 wks</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>9:00 PM</b> , from causes and on the date stated above.														
22a. SIGNATURE <b>Paul R. Woollslayer</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>4/2/67</b>						
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Woollslayer, M.D.</b>					22d. ADDRESS <b>Meyersdale, Pa.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Locust Grove Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Belleville, Mifflin, Pa.</b>							
24. FUNERAL DIRECTOR <b>Ruth Newman</b>					ADDRESS <b>Grantsville, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

CERTIFICATE OF DEATH

2450

011017

Rural Greenville 3 years 10 months 10 days

Goodwill Nursing Home, Greenville, S.C.

Class 1 8, 1960

June 17, 1962

Boysen

May 1962

Household

Goodwill

10

2

1000

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

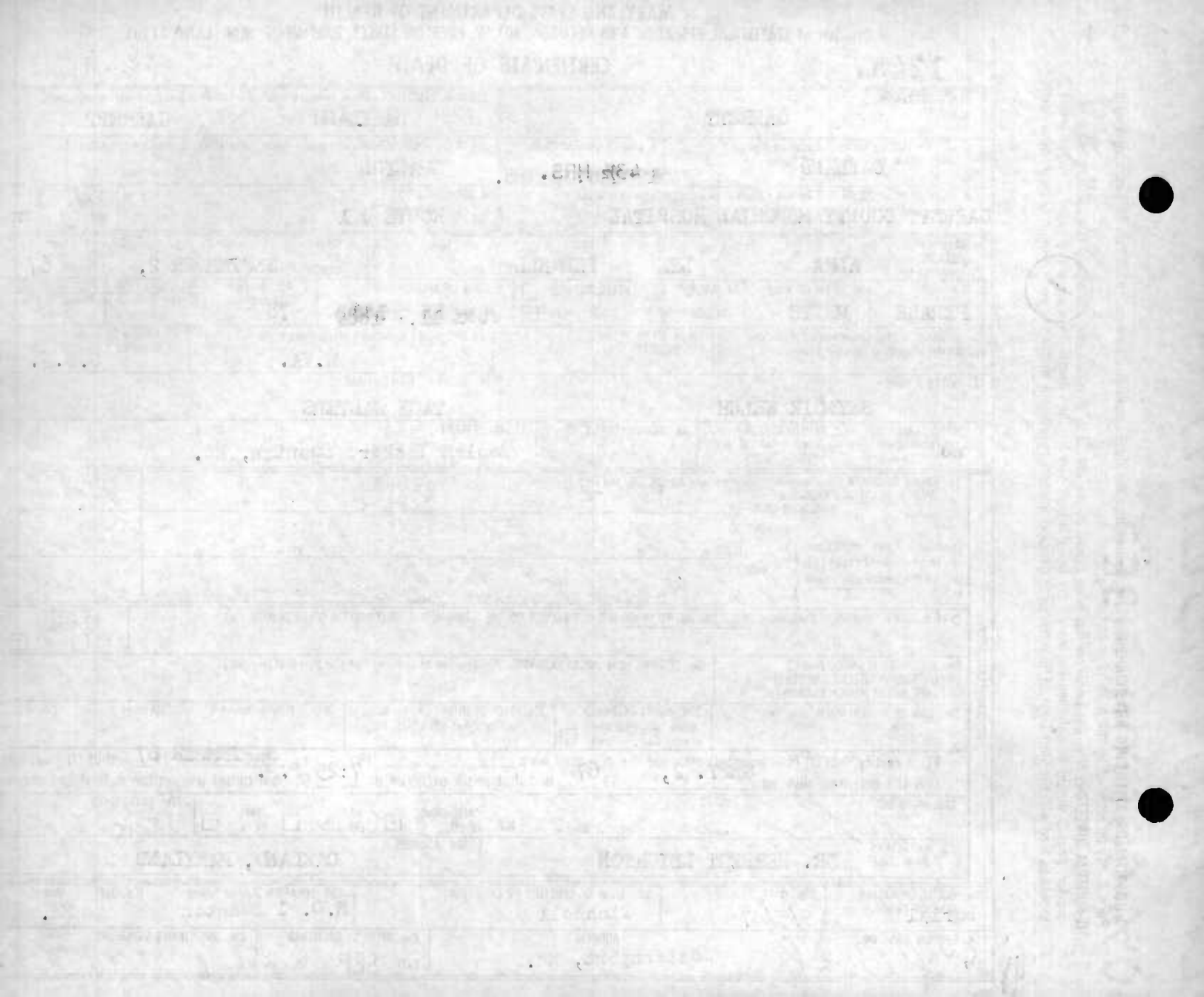
12457

## CERTIFICATE OF DEATH

12466

<b>1. PLACE OF DEATH</b> a. COUNTY <b>GARRETT</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>4 3/4 HRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>ROUTE # 1</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ANNA LEE PENNELL</b>		<b>4. DATE OF DEATH</b> <b>SEPTEMBER 2, 19 67</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JUNE 11, 1889</b>
<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>W. VA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>SEYMOIR WELCH</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>TACY WALTERS</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <b>Beulah Tasker, Swanton, Md.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4330</b> IMMEDIATE CAUSE (a) <b>Ventricular Stand-Still</b> DUE TO (b) <b>Adams-Stokes Syndrome</b> DUE TO (c) <b>Anteriodissecting Cardiovascular Disease</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.	
<b>20c. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20e. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept. 1, 1967</b> <b>to</b> <b>SEPTEMBER 67</b> , that (I) (we) last saw the deceased alive on <b>SEPT. 2, 19 67</b> , and that death occurred at <b>7:25 P.M.</b> from causes and on the date stated above.	
<b>22a. SIGNATURE</b> <b>DR. HERBERT LEIGHTON</b>		<b>22b. DATE SIGNED</b> <b>3 Sept 67</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b>		<b>22d. ADDRESS</b> <b>OAKLAND, MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>9/5/67</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Tichnell</b>		<b>23d. LOCATION (City or Town)</b> (County) (State) <b>R.D. 1 Swanton Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Westernport, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE SEP 8 1967</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25c. DATE</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12458

CERTIFICATE OF DEATH

12467

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett, Md.</b>		c. LENGTH OF STAY IN lb <b>1 Day 4Hrs 30 min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville, Md.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Garrett Co. Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Catherine</b> Last <b>Riley</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>27</b> Year <b>67</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-21-95</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Friendsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Thomas Benton Hinebaugh</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Lee</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-14-4829 D</b>		17. INFORMANT <b>Norris Riley</b> Address <b>Son Friendsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>diabetes mellitus</b> DUE TO (c) <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , to <b>9-27-67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-27-67</b> 19 <b>67</b> , and that death occurred at <b>1:30 PM</b> , from causes and on the date stated above									
22a. SIGNATURE <b>A. E. Mance</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Sept 27 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. E. Mance</b>				22d. ADDRESS <b>Oakland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/30/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sand Springs Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Garrett Co. Maryland</b>			
24. FUNERAL DIRECTOR <b>Leah M. Minnich</b>				ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 4 1967</b>			
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

STATEMENT OF DEATH

Deceased

John Smith

I, the undersigned, being a

competent person, depose and say that

the above-named John Smith died

on the 10th day of May, 1955, at

the County of Los Angeles, State of California

at the age of 45 years

and that the cause of death was

myocardial infarction

and that the death was

not

the result of any violence

or of any criminal act

W. A. E. Jones

Deputy Coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
20 M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12459

CERTIFICATE OF DEATH

12468

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		11-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>664 S. Third St.,</b>		d. STREET ADDRESS <b>664 S. Third Street,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FELIX</b> Middle <b>GRIFFIN</b> Last <b>ROBINSON</b>		4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 24, 1898</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Writer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	9. AGE (In years last birthday) yrs. <b>69</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Oakland, Garrett, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John G. Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Martha Hinebaugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>215-20-6139</b>	
17. INFORMANT <b>Mrs. F. G. Robinson, Oakland, Md.</b>		Address <b>(Widow)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Acute Myocardial Infarct</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>66</b> , to <b>Sept 11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Sept 11</b> , 19 <b>67</b> , and that death occurred at <b>7:30 P.M.</b> From causes and on the date stated above.			
22a. SIGNATURE <b>Herbert H. Leighton</b>		22b. DATE SIGNED <b>13 Sept 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M.D.</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/14/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Oakland, Maryland</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home, Oakland, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 18 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MINISTRE DE LA JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

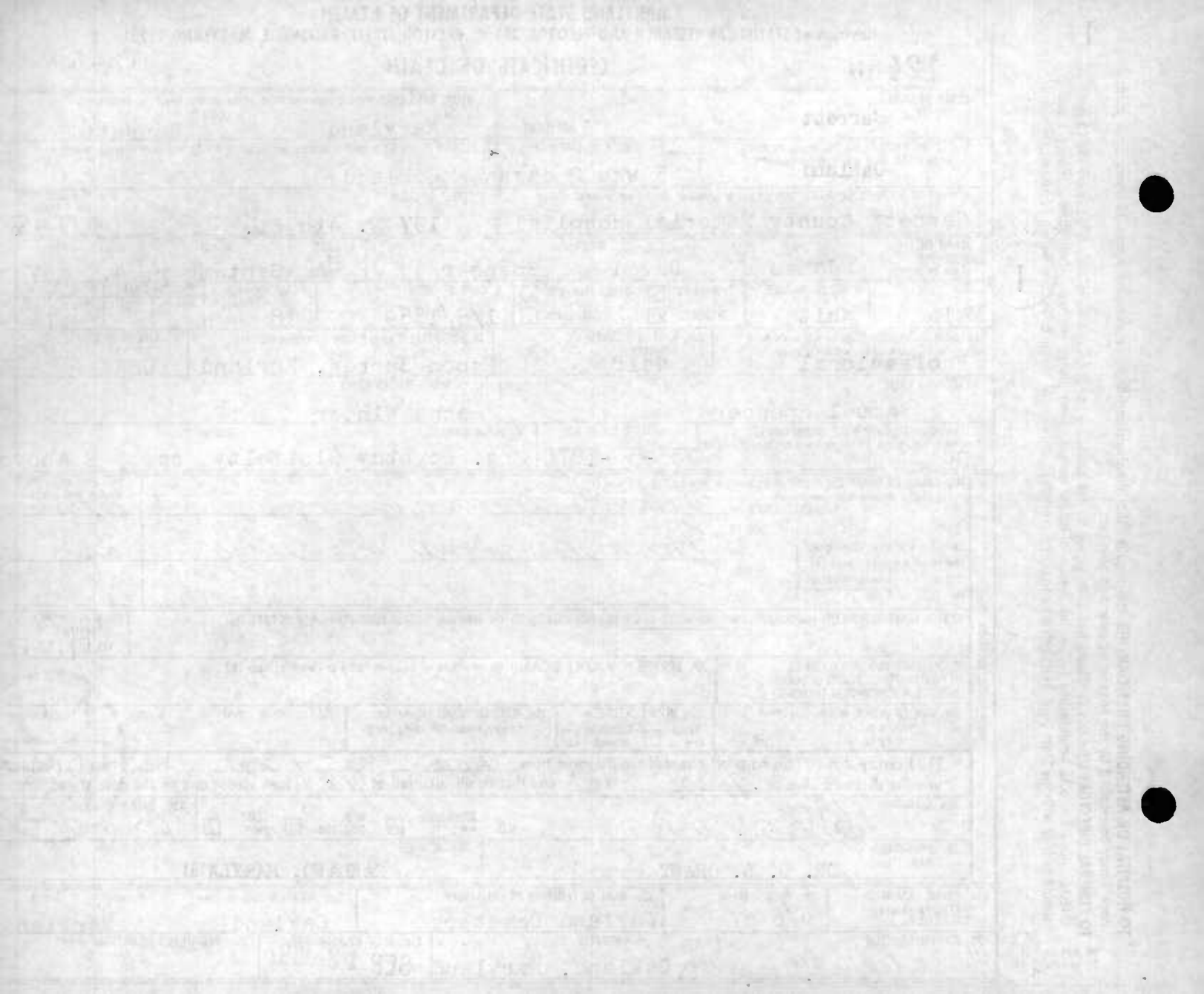
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12460

CERTIFICATE OF DEATH

12469

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS <b>137 N. 4th St.</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>David</b> Last <b>Spencer</b>		4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/5/1889</b>
9. AGE (In years lost birthday) yrs. <b>78</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professional</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Golf</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Espon Surrey, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Spencer</b>		14. MOTHER'S MAIDEN NAME <b>Anna Winter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>235-36-5878</b>	
17. INFORMANT <b>Mrs. Dorothy Glotfelty</b>		Address <b>see # 2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO <b>1621</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic carcinoma Lung</b> DUE TO <b>24yr</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Apr</b> , 19 <b>65</b> , to <b>Sept</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4 Sept</b> , 19 <b>67</b> , and that death occurred at <b>11 A</b> .M, from causes and on the date stated above.			
22a. SIGNATURE <b>B. L. Grant</b>		22b. DATE SIGNED <b>6 Sept 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. B. L. GRANT</b>		22d. ADDRESS <b>OAKLAND, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/6/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Oakland Maryland</b>
24. FUNERAL DIRECTOR <b>Gerald N. Minnich</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1967</b>	
ADDRESS <b>Oakland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



CERTIFICATE OF DEATH

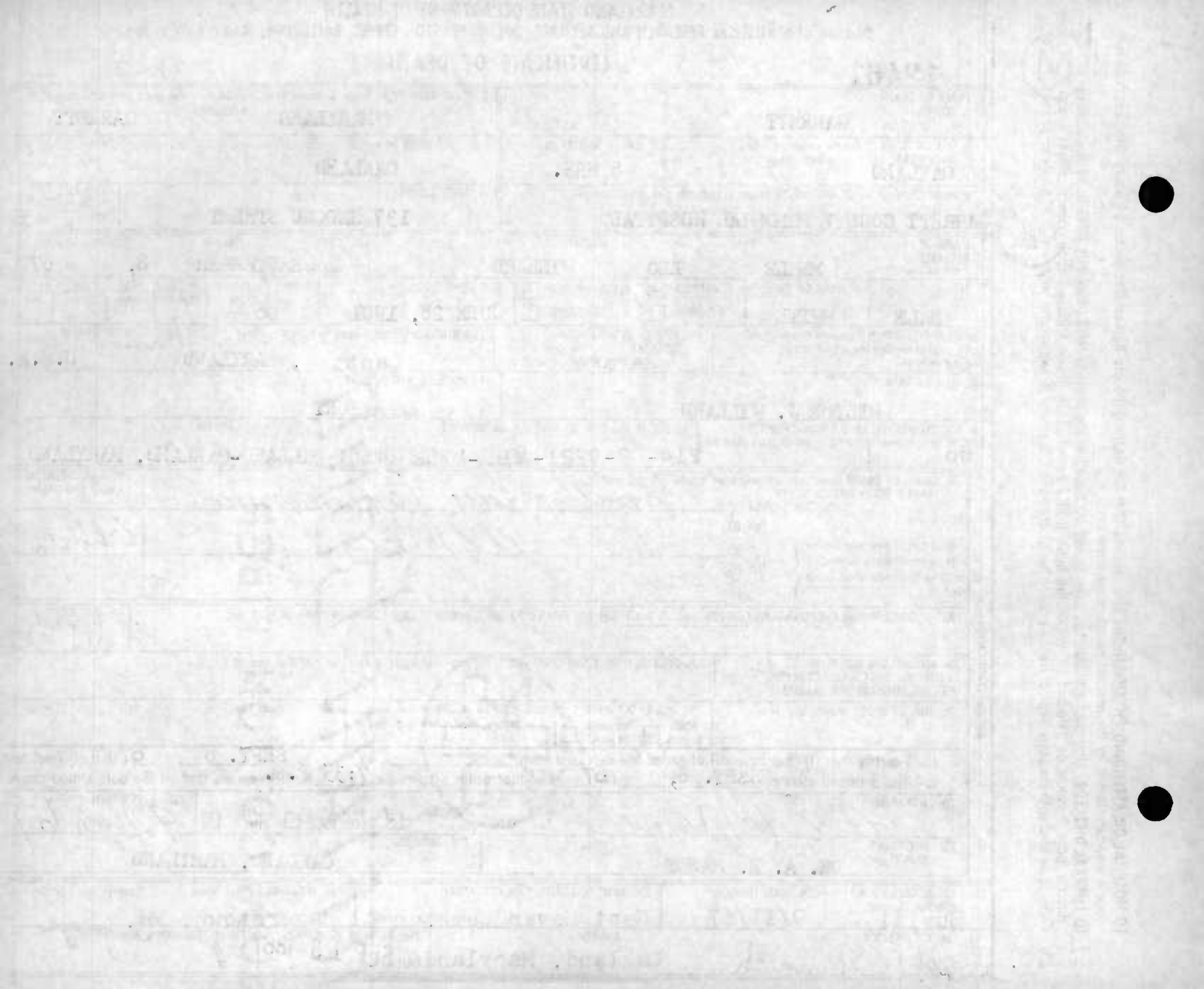
12461

12470

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>			c. LENGTH OF STAY IN lb <b>8 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>137 SECOND STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MERLE LEO WILLARD</b>				4. DATE OF DEATH <b>SEPTEMBER 8, 1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 28, 1901</b>	
9. AGE (In years lost birthday) yrs. <b>66</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lantz, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>MILTON J. WILLARD</b>				14. MOTHER'S MAIDEN NAME <b>EMMA FUNT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-9221</b>		17. INFORMANT <b>WIFE-AGNES ONEDA WILLARD-OAKLAND, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> DUE TO <b>left lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 Mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19 _____ to <b>SEPT. 8, 1967</b> that (I) (we) last saw the deceased alive on <b>SEPT. 8, 1967</b> , and that death occurred at <b>7:35 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>A. E. Mance</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9 Sept 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. A. E. MANCE</b>				22d. ADDRESS <b>OAKLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR <b>Gerald N. Minnich</b>				25a. REC'D BY REGISTRAR <b>SEP 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12462

12471

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BROWNFIELD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>1 mo.-20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROWNFIELD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA BELLE LEE WORKMAN</b>				4. DATE OF DEATH Month Day Year <b>SEPTEMBER 14, 1967</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 30, 1927</b>		9. AGE (In years last birthday) <b>39 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>GARRETT - MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HAROLD ELSWORTH COSNER</b>				14. MOTHER'S MAIDEN NAME <b>ZELDA BURGESS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT (MOTHER) <b>ZELDA COSNER</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO (b) <b>Adenocarcinoma of Esophagus</b> stating the underlying cause last. (c) <b>150X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>1 Year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/11, 1967</b> , to <b>SEPT. 14, 1967</b> that (I) (we) last saw the deceased alive on <b>SEPT. 14, 1967</b> , and that death occurred at <b>12:30 P.M.</b> on causes and on the date stated above							
22a. SIGNATURE <b>Herbert H. Leighton</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>16 Sept 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>HERBERT H. LEIGHTON, M.D.</b>				22d. ADDRESS <b>OAK STREET OAKLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/17/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bismark Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bismark, Mineral, W.Va.</b>	
24. FUNERAL DIRECTOR <b>Leighton-Durst Funeral Home, Oak land, Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

